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ABSTRACT

Critical reasons for frustration and circularity in the formulation and implementation of mental health policy are analyzed. The primary reason proposed is the lack of equal, systematic and structurally-reinforced participation of mental health services consumers and their communities in the planning and implementing of policy and programs. This is why mental health policy and services are often ineffective, inefficient and irrelevant to those who need them. A proposal for a two-year strategy for service acquirer participation is made to avoid some of the typical difficulties encountered in facilitating consumer involvement. (BN)

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Rethinking Mental Health Policy*

by

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Important concerns about the state of our national mental health continue to be expressed. The President's Commission on Mental Health was established in February 1977, with the purpose of assessing what the nation's mental health needs are, how well they are currently being met, and what those needs are projected to be over the next 25 years. Also, the Commission was charged with determining how the federal government can best coordinate a unified approach to all mental health and people-helping services, what the costs of such programs would be, how they can best be allocated, how prevention programs can best be developed, and what mental health research priorities should be. The Commission was given 10 months to conduct their inquiry and produce a Final Report.[22]

The creation of the Commission and President and Mrs. Carter's well-publicized interest in mental health programs inspired new hope for the development of creative mental health policy after the lean Nixon and Ford years. However, early reactions to the Commission's Preliminary Report seem less than enthusiastic. Behavior Today of October 10, 1977 reports a feeling of "sympathetic dismay" on the part of professionals they contacted. Although Mrs. Carter's (as Honorary Chairperson) sincerity and commitment were unquestioned, the following reaction was reported as representative:

> "All those releases and sub-panels," one source commented, "and all those promises that we're not going to 're-invent the wheel,' and in the end they re-invented the wheel. It's a nice wheel, of course, and well-made as far as it goes, but when you look at it closely all you see is a lot of spokes, with Mrs. Carter at the hub." (p. 1)[8]

It is not our intention to attempt a premature critical analysis of the Commission's ultimate findings but rather to point to a recurring problem in the way mental health policy has been handled in this country. The metaphor "re-inventing the wheel" is an interesting one, and it calls to mind the concept of the Third Revolution in mental health which we have allegedly been experiencing since the Community Mental Health movement gained impetus in 1963. Sabshin notes that "revolution" has two meanings--1) the forcible overthrow of a political or social system, and 2) a circuitous pathway around a central point. Obviously it is the first definition which proponents of CMH allude to, but Sabshin suggests that the history of the CMH movement has much in common with the second.[43] "Re-inventing the wheel," "going in circles," "spinning our wheels," are metaphors which accurately describe the way many mental health professionals and policy-makers feel in the frustrating business of gaining the public and political support necessary to deliver effective services to those who need them.

The mental health world is at a curious and critical point in its history. On the one hand, it has emerged from a six-year period of political disfavor and subsequent funding cutbacks, and once again seems to stand high on the priority list of values espoused by the new administration. However, there is a difference from the Kennedy and Johnson administrations when the "bold new approach" sparked soaring hopes in the hearts of mental health professionals, and spurred Congress to appropriate generous amounts of money for training, research and service delivery. This time, although the mental health needs of the nation are in the forefront of the Carter Administration's

rhetoric, there is no automatic assumption that simply by increasing funding to professionally-run programs will those needs be met. Add to that the fact that the Congressional mood has not been unquestioningly enthusiastic in response to the President's priorities, and it is clear that the future of mental health programs is still very uncertain.

This paper attempts to analyze more closely the reasons behind this precarious balance in the mental health picture. We intend to identify what we believe to be a critical reason for the sense of frustration and circularity in the formulation and implementation of mental health policy. We propose this reason to be the lack of equal, systematic, and structurally-reinforced participation on the part of mental health services consumers and their communities in the planning and implementing of policy and programs. We contend that the exclusion of the service acquirer perspective from the local community level up to the federal level is the main reason why mental health policy and services are often ineffective, inefficient and irrelevant to those who need them. And finally, we propose a strategy for service acquirer participation which attempts to overcome some of the typical difficulties encountered in facilitating consumer involvement, and thereby re-draw the boundaries of the mental health service system.

Overview of the CMH Movement

We will not attempt to recount the history of the CMH movement; this has been accomplished by others.[15, 19, 32, 38, 40] However, an overview of the major issues that comprise that history may be useful.

First, the CMH movement can be understood as "revolutionary" in several

ways. Most evident is the fact that for the first time the federal government assumed responsibility for funding a substantial amount of direct mental health service. It took away from the states initiative and control over reforming publicly-supported mental health services and gave it to the National Institute of Mental Health, then an upstart bureau which represented the interests of the new breed of community psychiatrists. As Musto describes it, "NIMH leaders were also troubled by something else in these reports--the question of control. If federal mental health policy were to make the required major departure, it was necessary that only NIMH psychiatrists, rather than conventional bureaucrats, have control over planning, budgeting and operation of the national community mental health program." (p. 30)[40] Thus not only was the power of mental health service delivery substantially moved to the federal level, it was also vested in a much more professionally-dominated arm of government. Unlike many other federally-controlled programs, policy-making, program planning, implementation and evaluation all became controlled by the mental health professions.

Second, the CMH movement proposed not only to treat the mentally ill, but also to change society, "to alter the ways in which society promotes the mental health of all its citizens and responds to mental illness in some of them." (p. 2)[32] In embracing the findings of the behavioral sciences which continued to stress the relationship between environmental factors and mental disability, many CMH proponents led Congress and the public to believe that extensive, generously-funded and professionally-run mental health programs could have significant impact on the pressing problems of society. According to Zusman and Lamb, "the overselling of prevention has probably been

a major factor in causing people to become disillusioned with community mental health." (p. 887)[52] Still other critics maintain that prevention was never a serious priority of the early CMHC promoters, and subsequent guidelines and funding patterns did little to encourage prevention programs.[44]

The issue of whether or not CMH professionals should or could provide effective prevention raised other problems as well. Accusations of "social engineering" and "psychiatric tyranny" flew as mental health professionals debated the ethics of political action. But as Mechanic puts it, "Even if we had complete power to change society, however, it is presumptuous to believe that we have the knowledge to bring about the results we desire. (p. 169)[38]

The other revolutionary goal of CMH was to provide community-based services to a large number of chronically and seriously mentally ill people who in the past were placed in the state hospitals to receive largely custodial care. Early proponents envisioned a "withering away" of such large facilities, made possible through CMHC's providing early detection and prevention, brief hospitalization, partial hospitalization, after-care and other supportive services. Widespread use of community-based transitional facilities and sheltered environments was anticipated. It would seem that this goal would be the easiest to evaluate by examining state hospital admissions and population statistics. Although CMH supporters frequently point to the overall decrease in the populations of state hospitals by almost 42% in the last 10 years, it is not clear that the CMHC's themselves have played a central role in that decrease. Windle and Scully report that although CMHC's have played a role in retarding admissions rates in state hospitals, they have not contributed significantly toward an overall reduced resident rate.[51] Those patients who are discharged

often wind up in just another custodial setting and receive either sporadic or no follow-up services.[15, 31, 33] Zusman and Lamb state:

> The major emphasis on reducing state hospitalization by administrative fiat without a corresponding effort to implement community treatment and rehabilitation of the long-term, severely mentally ill has not resulted from a lack of knowledge--effective community treatment techniques have been demonstrated and reported for years. Instead, community mental health has tended to focus on treating the "healthy but unhappy." (p. 889)[52]

Other criticisms levied against CMH include inadequate management, lack of evaluation, lack of meaningful consumer participation, lack of inter-professional cooperation, and a host of others.[15, 17, 21, 25, 31, 32, 33, 36, 43, 44, 47, 51, 52] The literature is complete with arguments on both sides of nearly every question. The "bold new approach" has had 15 years to show that it could make significant changes in the mental health picture of this country. Today, not only is harsh criticism coming from outside the mental health establishment, but many professionals themselves feel disillusioned and "burnt out."[43] The question then remains, what is the key to turning the situation around and making real progress in meeting the nation's mental health needs?

Assumptions of the Status Quo

Although several of the assumptions underlying the CMH movement were tru-

ly revolutionary in concept, the movement has rested on a central notion that we believe is key to understanding the serious problems it has experienced. This assumption is that the determination of the nation's mental health needs, priorities, and programs can best be made by mental health professionals. Assuredly, opinions among professionals vary tremendously; we are not postulating the existence of a monolithic professional viewpoint. But both the advocates of the CMH movement as well as its critics have assumed that enlightened professional expertise should be the dominant force in mental health policy-making and programming.[26,28,29,30,32,38,42,43,47,52] As indicated earlier, the vesting of NIMH with the power to implement and regulate CMH legislation was an unusual concentration of power in the hands of the professional world who would reap its benefits. To a large extent, the claims of mental health professionals went relatively unscrutinized by the political and bureaucratic process in those early years.[15]

However, not only were mental health professionals placed in policy-making control of their programs, they were at the same time promising that given half a chance, they could transform society. Whether one followed the tenets of the "medical model" of traditional psychiatry, or agreed with Szasz in decrying the "myth of mental illness," the result was the same. As Musto says, "The battles that erupted in some communities between the two groups and considerably harmed the CMHC idea were so intense and dramatic precisely because both sides shared the fantasy of an omnipotent and omniscient mental health technology that could thoroughly reform society; the prize seemed eminently worth fighting for." (p. 50)[40]

The sense of spinning one's wheels recurs when we realize how much of

the CMH movement's difficulties derive from simple ignorance on the part of professionals as to what causes, prevents and cures mental illness, to say nothing of disagreements over issues as basic as what exactly is mental health and mental illness. But the assumption persists that given enough time, the professionals will thrash out the answer. Thus, when NIMH was criticized for not requiring evaluation studies of CMHC's effectiveness, the reply was that no adequate evaluation methodologies were available to provide meaningful findings.[14, 15] Without suggesting that the state of evaluation research is capable of the task, one must question the adequacy of such a reply. It does imply a "Trust us, we're doing our best" attitude which is at odds with the notion of accountability to the people supposedly served.

Indeed, it is this absence of accountability that underlies most criticisms of the CMH movement. In mental health, accountability is even more difficult to operationalize than in other services. Not only must we ask, "Is the public getting its money's worth?" but also "What exactly is the public getting? What more could it get? Is it getting what it needs? And can it only be provided by mental health professionals?" Throughout most of the past 15 years, those questions have been asked and argued primarily among professionals. Definitive answers have not been forthcoming, and the public and Congressional mood is no longer one of faith in the collective wisdom of the professional world. "This new skepticism, accompanied by demands--even within Congress--for proof of effectiveness, is perhaps the most serious obstacle that the CMHC's and the mental health profession will have to face." (p. 50)[40]

The Culture of Professionalism

In the preceding overview of the problems of the CMH movement we have

tried to not only summarize what are considered to be its failures, but also to point out that attempts to correct the problems have not succeeded primarily because the mental health professionals who are in control of all phases of the program cannot agree about how to do so. The program admittedly suffered severe funding cutbacks; however, there is little evidence that the CMHC's would have been significantly more effective even with optional funding.[15]

But is it enough to assert that lack of organization and professional common purpose were the only factors? As Mechanic points out, even if mental health professionals agreed about how to solve the nation's mental health problems, and possessed the technology to do so, it is extremely unlikely they would be allowed to since mental health is just one priority among many in our society.[38] The notions that professionals could ever come up with an agreed-upon technology and be allowed to implement it seem absurd when reflected upon, and yet we believe those two ideas are accepted by most people, professional and consumer alike. We contend that this faith in "professionalism" as it is practiced by professionals and supported by consumers is the central problem in all human service delivery systems, and particularly in mental health.

What are some of the characteristics of this kind of professionalism?*

1) Professionals, by virtue of their training, possess superior knowledge about a certain aspect of human life that sets them apart from the rest of the population. In the field of mental health, that means that professionals are supposed to know more

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*See Burton Bledstein's THE CULTURE OF PROFESSIONALISM[12] for an extensive analysis of this topic.

about what people need to be mentally healthy or to overcome mental illness, than do their clients.

2) Because of this superior knowledge, professionals deserve to have more power and authority in determining what services involving their expertise should be than their clients or the political system.

3) Professionals should be primarily accountable to their profession, secondarily to society at large, or to the organization which may employ them. It is assumed that primary accountability to the profession is identical with accountability to the client. It often is not.

The irony of the concept of professionalism is that while individual achievement through hard work and self-sufficiency is believed to lead one to the realm of professionalism, the perpetuation of professional power depends on the blind faith and acquiescence of the vast majority of people. Karno and Schwartz compare the role of client in any human service system as similar to that of a child, with the professional acting as parent. They state, "Even more we believe that the failure to recognize the existence of the parent-child model as the principal one in all service systems is itself an impediment to the development of the rehabilitative stance." (p. 103)[22] They emphasize, furthermore, that "clients and professionals alike appear to be comfortable with the client in the less autonomous role of the child-adult than

they are when he is asked to assume more autonomous roles in the process." (p. 106)[32]

This uneven balance of power exists not only in the one-to-one relationship between client and professional. It carries over to the relationship between professional service delivery systems and the general society. McKnight points out that as a whole population we are becoming more and more dependent on a service economy, and thus are becoming a nation of clients, who in the aggregate tend to be more valuable in terms of the GNP for our disabilities, not for our individual self-sufficiency. He offers a disturbing case in point:

> Consider your own value in a serving economy should you die of cancer next year. If you have a long, fully-treated "quality-care" death, its value could appear within next year's Gross National Product as $250,000. There are very few people who can be that productive in one year, or several years. (p. 37)[37]

As a whole society it seems as though we have come to the breaking point in our tendency to throw the burden of meeting human needs to the professional world. Historians, sociologists and other professional interpreters of the past offer several theories to account for this, but the fact remains that with the disintegration of small, family-oriented communities and the growth of individual isolation and social fragmentation, we have turned more and more to the culture of professionalism and faith in technology to meet our human needs. There is a need to reverse the trend of increasing dependence on professionals

to solve every problem, and conversely professionals must begin to refuse the mantle of omnipotence, regardless of how ego-fulfilling it might feel at the moment. We do not claim that mental health professionals have little to offer society; simply that their contribution can be no greater nor more certain than any other constituency in society. As Musto states,

> Psychiatry and the allied professionals offer essential services not only to troubled individuals but to our general society as well . . . The persistence and effects of behavioral problems are not greatly altered by rhetoric--no more than "sick" communities could be reformed through homilies on community psychiatry. By endorsing and supporting psychiatry's more grandiose claims, the CMHC program's most enduring contribution may have been to lead the profession to a clearer sense of reality and of its own areas of greatest competence. (p. 55)[40]

The Balanced Service System

We have suggested that the elevation of professionals to dominance and authority over human service systems reinforces a dependent, child-like attitude on the part of clients that works against the client becoming rehabilitated and capable of future autonomous problem-solving. We have also suggested that this dependence operates on a systems level as well as on the individual therapeutic level. We will elaborate further on this systems perspective through the concept of constituencies.

We postulate that any human service system is composed of four generic constituencies. These are:

a) Resource Providers: Persons who provide the system with funding, legitimacy, human resources, and who also make policy, regulate and monitor the activities of the system. In mental health these would include funding agencies, boards of directors, accrediting agencies, the Congress, state legislatures, etc.

b) Technology Developers: Persons who design and implement the services of the system. This in mental health would include researchers, teachers in training institutions and individual mental health professionals as they continually refine and expand their repertoire of skills in delivering mental health services to their clients. It also includes planners, managers and administrators of mental health services at the federal, state and local levels.

c) Direct Service Providers: Persons whose primary role is to serve in direct contact with the client in assessing and meeting client needs. In mental health, these would include professionals, paraprofessionals, support staff of hospitals, CMHC's, and other mental health service agencies.

d) Service Acquirers: Persons who are the current or potential recipients of the service. In mental health, these would include clients, their families, advocate agencies, and the community in general.

An individual usually can choose one constituency he or she primarily identifies with in relation to a particular service system. Thus, if my job is director of a CMHC but also involves some direct therapy as well, I will still primarily identify myself as a technology developer with regard to the CMHC. However, in considering which constituency I belong to in relation to the health care system in my community, I might consider myself primarily a service acquirer. The key concept here is role awareness in relationship to a particular service system.

A human service system develops in response to the perception of a service need as it is held by the service acquirer. Therefore, in order for there to be a reason for a service system to evolve, there must be a pre-existing needs environment. The needs environment is "produced" by those with the needs, i.e., the service acquirers. It derives from their experience alone, and can be articulated and known by members of that constituency alone. Therefore, in order for a service system to be effective in delivering relevant services to service acquirers, the service acquirer constituency and their needs environment must be the focal point of the system. This means that the service acquirer constituency must have the power to control the prioritizing, planning and implementing processes of the service system.

Most human service systems today do not have the service acquirer constituency as their focal points. Rather, the balance of power is in favor of the resource provider and technology developer constituencies who usually mistakenly believe that they can better perceive, understand and articulate the needs of the service acquirer constituency. Thus, the control of the mental health service system is firmly in the hands of the resource providers (particularly gov-

ernmental funding and policy-making agencies) and technology developers (the four mental health professions, their training and service-delivery agencies) with virtually no power held by consumers, or the communities in which the services reside.

We suggest that the central problem is one of system power imbalance. Only when service acquirers organize themselves into effective service acquisition systems which are independent of and able to negotiate with the service delivery systems, will mental health needs begin to be really understood and met.

What is a service acquisition system? How does it differ from citizens boards, advisory groups, and self-help networks?

First, citizens boards and advisory groups typically are appendages to the professionally-dominated service delivery system. Their composition is spelled out by top-down regulations; the criteria for selection is usually biased toward those who hold the power; their membership is chosen by the system's professionals; and their representation is usually elitist. Even when agency professionals attempt to put together an active representative board they often end up playing numbers games with federal quotas.

In addition, such boards typically have problems functioning effectively. Members may be intimidated by professionals, overwhelmed with their task, antagonistic and uncooperative, uninterested, too busy, and unreliable.[16] "Maximum feasible participation" in many circles has become a euphemism for reluctant compliance.

Self-help networks and mutual aid groups come somewhat nearer to the concept of a service acquisition system. Such groups tend to be formed by per-

sons who once were clients, patients, or consumers of the needed service themselves and who found the existing service system inadequate. Thus, self-help groups have formed to aid former psychiatric patients, prison inmates, alcoholics, drug addicts, single parents, widows, cancer victims and arthritics, and their numbers are increasing every day.[45] In addition, local community action groups have experienced a resurgence in the past few years, after lying nearly dormant in the aftermath of disillusionment that followed the activist 1960's. These kinds of movements tend to share one thing in common: they are anti-establishment and anti-professional; they are reactions against the inadequacy of the job being done by the regular service delivery systems, and thus they turn away from those systems and attempt to rely solely on themselves or others like them to meet their respective needs.

While it is clear that the proliferation of the self-help, alternative services movement is a step in the direction of returning control over one's life to one's own hands, it still does not provide a way to negotiate with the existing political or service systems when it becomes necessary. At best, it sets up a kind of adversary relationship which often is reconciled in the favor of the established powers, not the alternative system.

We believe then that what is needed is a way by which people gain more and more control and power over the services they need so that they become empowered to negotiate and impact successfully upon the service delivery systems they must inevitably deal with. We believe that in this way not only will the alternative systems become strengthened, but at the same time traditional professionally-controlled systems will become more responsive to the needs of the people they sincerely aim to serve. We further maintain that these goals are

not necessarily in conflict with the long-range goals of the professional mental health community or the governmental policy-making and funding agencies, but rather represent a feasible way of meeting the goals of delivering improved service to those who really need it.

The Service Acquisition System

The following is an example of such a system:

A CMHC is located in a predominantly rural catchment area with a population of 150,000 spanning 4,000 square miles. The Center has outlying clinics in all counties, good relations with the local communities, a competent and dedicated staff with excessive caseloads, reasonable financial stability, a strategic plan for becoming independent of federal funds after its staffing grant expires, accessibility to good hospital resources, 2 full-time psychiatrists; in short, is in "good shape" in most of the areas that prove to be trouble spots for many Centers. It has a fairly active Board of Directors, advisory boards for each outlying clinic, good management. However, the Center has no systematic evaluation plan, no discernable consultation and education program, little emphasis on prevention. The staff's priorities are to help the most disabled clients, to keep as many out of the state hospital as possible, to keep up with the chronically mentally ill. The Center is attempting to fulfill one half of the mission of CMHC's--that of keeping patients out of the hospital 'warehouses' and maintained with some quality of care within the community. But it has no funds to support transitional facilities, and inadequate staff to provide sufficient aftercare services. Prevention and integration of mental health services into other community services are admirable

goals the Center wishes it could pursue with vigor, but caseloads are too heavy, and the priority is elsewhere.

Four years later, some changes have occurred. The Center is still the focal point of mental health service delivery in the catchment area, but there is another organization which is equally influential. It is called the Community Mental Health Planning Council, an independent constituency-based entity. Its purpose is to conduct continuous assessments of the mental health needs and priorities of the catchment area and formulate an annual strategy for those needs to be met, utilizing the resources of the CMHC, other local service agencies, schools, churches, and volunteers. Although the CMHC still provides the 10 essential services of a comprehensive center as spelled out by federal guidelines, those services have become more focused and specific in response to the overall plan produced by the independent planning council.

Some of the resulting changes in mental health service delivery include the following: 1) At the point of intake, the intake worker at the CMHC will ask a prospective client if s/he would prefer to be referred to any of a number of community-based self-help groups or counseling programs rather than automatically admitting him or her to the Center's program. 2) The follow-up and aftercare services to formerly hospitalized patients are now conducted primarily by volunteers who provide transportation, home visiting and day care services that draw on the expertise of the Center's medical and other clinical staff but are controlled by the community. 3) A parents' network working in conjunction with the schools and the Center operate a program to work with children with learning disabilities and behavior problems in the early grades, to prevent their growing into more serious problems later on. 4) A 24-hour hotline is staffed strict-

ly by volunteers with professional backup, and serves as the emergency phone service for the Center.

The Council is able to negotiate with the Center and other agencies because it represents a broad base of active community support which is extremely influential with local funding sources, expecially the county courts. The Council is also finding itself increasingly influential with state level representatives and on nearby professional training institutions. Every year the Council presents to the Center's Board of Directors its strategic plan with specific requests for Center participation and suggestions for Center goals. The Center's role in the plan is negotiated prior to the time when county courts made their budget decisions; if the Council and the Center can present a united front, the chances for the Center's receiving sufficient funds are greatly enhanced.

The Council is composed of 50% service acquirers, 25% mental health professionals, and 25% resource providers. The Council's job is to determine mental health policy and approve an implementation strategy. The Council is elected by the constituencies and each member serves a two-year term. Each Council member represents one of the member constituencies. The Council is not under the control of any other agency; it is an independent, incorporated entity. The budget of the Planning Council itself is very low--with most of the resources accounted for as "in-kind."

The preceding scenario is a fantasy, but is based upon actual experience in parallel situations. It describes what happens when service acquirers are provided with resources to organize themselves into a power that decides what services are needed and how they can best be provided. The CMH Planning Coun-

cil is the organizational manifestation of the mental health service acquisition system in a rural CMHC catchment area, and it derives its power, legitimization and direction from the people who receive mental health services. Let us extract from the previous description some of the salient points of this kind of system:

1) It is dominated by the user constituency. The Council is "stacked" with service acquirers; there are professionals on the board, but they are in the minority.

2) It has the power to negotiate on an equal basis with the service delivery system (in this case the CMHC). It has this power because of its ability to muster a great deal of community support or opposition--something the Center is dependent upon in order to be financially secure.

3) It has a bias towards attempting to meet its own needs before it looks to the professional delivery system for solutions. It looks to "people who have been there before" to help others with similar problems; it prefers to see services offered in familiar surroundings, by familiar people at little or no cost. It gives top priority to erasing the stigma attached to seeking mental health services by demonstrating that, in many cases, mental health services can be offered in the context of everyday life.

4) It does not try to ignore or destroy the professional system, but rather recognizes what resources are there, and dictates the terms under which the professional system delivers its services. It retains the

right to its expertise concerning its own needs, and recognizes the professionals' right to their own. Thus, while the service acquisition system feels justified in having a dominant voice in deciding what the service priorities of the community are, it does not attempt to dictate to the professional the specifics of his or her technique. Rather, overall results and community satisfaction are the chief criteria with which the professional system is evaluated.

5) It recognizes that the chief responsibility for community mental health is within the community, not within the professional delivery system.

6) It typically creates a new kind of direct service provider who often emerges from the ranks of the service acquirers, but who finds a new opportunity to deliver services from an acquirer perspective. These people may go on to be trained as professionals, after they have developed an acquirer bias. The word "paraprofessional" is particularly unsatisfactory to describe such people; a new term will have to be created from the experience of such a person that will accurately express what that function is.

7) It recognizes the legitimacy and importance of non-monetary in-kind resources as its main source of support.

Developing a Constituency-Based Service Acquisition System*

Assuming that such an indepenent, community-based service acquisition sys-

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*See papers by Bartee and Cheyunski [2, 3, 4] and Bartee & Rondinelli [5] for full development of the constituency-approach.

tem is a potential answer to some of the mental health service problems we face, how does such a system develop? It is very unlikely that one can develop spontaneously for two reasons:

1) Existing service delivery systems are structured in such a way that reinforces the power held by the resource provider and technology developer constituencies. Until these structures are changed, the balancing of power among constituencies is unlikely to occur.

2) Service acquirers typically are fragmented and often experience themselves as deserving to be subordinate to the expert system, or powerless to change the situation, or without the skills to even attempt it. Thus a successful service acquisition system is unlikely to develop through the initiation of either sincere professionals who are part of the service delivery system, or service acquirers alone.

Therefore we believe the actual task of organizing and developing the service acquisition system must be undertaken by a team of external intervenors. These persons should not come from any of the constituencies which make up the particular service system under consideration, and should be as attitudinally neutral as possible regarding the content of the system's programs. The intervention team assumes that all the necessary information about what the subject mental health service system needs is contained within the four constituencies of that system.

The external intervention team goes through a deliberate process of facilitating constituency organization and development. The major steps in this process are as follows:

1) Develop and maintain a relationship with the system's umbrella function (key members of the system and its surrounding community whose support is essential to the success of the developmental process) so that the intervention is protected from premature evaluation;

2) Identify and organize the relevant constituency groups within the system;

3) Facilitate each constituency group as it undergoes a structured problem-solving process around its perception of what the system needs;

4) Assist the umbrella function members in managing and resolving inter-constituency conflict and negotiation;

5) Provide initial advocacy for the developing service acquirer constituency.

The developmental process usually takes a minimum of two years to create a fledgling service acquisition system. At the end of the two-year period, the new system is substantially independent of the external intervenors, but requires another two years to become a fully functioning independent entity.

Karno and Schwartz state:

> The currently popular slogan, 'power to the people' is generally beloved of those who take a more radical and militant stance against the establishment. It is, therefore, viewed with some distaste by many members of the establishment. We think that the attitudes of both groups may be misplaced. Those who would overthrow the established order

> need do no more than encourage the current and unsuccessful efforts to solve service needs by continuing to promote the dependency of service clients. The system is in danger of falling of its own weight if it continues on its present tack. The development of power to the people, that is the development of approaches which promote the participation of the clients of service systems as active partners in the management of the systems may be the only way open to a maintenance of public order within the present framework of the social structure. (p. 115, 116)[32]

These words eloquently state the critical need for empowered service acquirer involvement. But priority must be placed on research and development of implementation strategies such as the constituency-based approach. Without such specific strategies, consumer participation will remain largely unrealized, and its potential impact will become frustrated at the level of rhetoric and platitude.

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